STATEMENT OF KIRK W. LOWRY
to the
Insurance and Real Estate Committee

February 10, 2011

SUPPORT FOR SB 877
Concerning Mental Health Parity

I am the Legal Director of the Connecticut Legal Rights Project, Inc. (CLRP) a statewide nonprofit organization that provides free legal services to low income adults with psychiatric disabilities.

CLRP supports SB 877 because it would strengthen the parity between group health insurance coverage for mental health conditions and medical, surgical or other physical health conditions.

Connecticut mental health parity law is broader than federal mental health parity in that it mandates coverage for mental or nervous conditions as defined in the Diagnostic and Statistical Manual of Mental Disorders and covers all group health plans. Federal parity only covers group plans offered by employers with 51 or more employees and does not require coverage of conditions in the DSM.

Connecticut parity prohibits terms, conditions or benefits that place a greater financial burden on the insured. Federal parity prohibits financial limitations and treatment limitations that are unequal. Treatment limitations include quantitative limitations and non-quantitative limitations. Non-quantitative limitations include:

> (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
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> (B) Formulary design for prescription drugs;
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> (C) Standards for provider admission to participate in a network, including reimbursement rates;
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> (D) Plan methods for determining usual, customary, and reasonable charges;

(E) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and

(F) Exclusions based on failure to complete a course of treatment.

(75 Federal Register 5410, 5416, 5436, Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, February 2, 2010.)

The federal Mental Health Parity and Addiction Equity Act of 2008 does not preempt the broader provisions of the Connecticut parity law. The preemption provisions of section 731 of ERISA and section 2723 of the PHS Act (added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the MHPAEA requirements are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of MHPAEA. The HIPAA conference report indicates that this is intended to be the "narrowest" preemption of State laws. (See House Conf. Rep. No. 104-736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.) (75 Federal Register 5410, 5418)

The result will be that the strongest provisions of both statutes will be Connecticut parity law.

People with mental illness die 25 years earlier than people without mental illness. Access to integrated mental health treatment is essential for people with mental illness and reduces inpatient treatment utilization. Studies have shown that broad parity law increases access to care but does not significantly increase costs. (75 Federal Register 5410, 5424-25.)

The primary purpose of the MHPAEA is to improve access to mental health and substance use treatment benefits by eliminating discrimination that existed with respect to different benefits and costs for mental health and substance use treatment as compared to general physical health benefits and costs. The MHPAEA increases access to health care and decreases discrimination against people with psychiatric disabilities and substance use diagnoses at minimal cost.